STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155572	A. BUILDING _____ B. WING _____	03/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN HILLS HEALTH AND REHAB CENTER	10352 N 600 E COUNTY LINE RD DEMOTTE, IN46310

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F0000	This visit was for the Investigation of Complaint IN00086395. Complaint IN00086395- Substantiated, Federal/State deficiencies related to the allegations are cited at F314 and F514. Survey dates: February 28 & March 1, 2011 Facility number: 000471 Provider number: 155572 AIM number: 100290390 Survey team; Kathleen (Kitty) Vargas, RN, TC Census bed type: SNF/NF: 48 SNF: 9 Residential: 12 NCC: 11 Total: 80 Census payor type: Medicare: 9 Medicaid: 45 Other: 26 Total: 80 Sample: 5 These deficiencies also reflect State	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on March 2, 2011 by Bev Faulkner, RN			

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F0314 SS=D	Based on observation, record review and interview, the facility failed to provide the pressure ulcer treatment as ordered by the physician to promote healing, for 1 of 4 residents reviewed with pressure ulcers in a sample of 5. (Resident #E) Findings include: a. Resident #E was observed in bed on 2/28/11 at 12:05 p.m. The resident had oxygen in use with oxygen tubing in place around his ears. The resident had no dressing in place behind his left ear. The resident was observed at 1:20 p.m., and at 3:10 p.m., on 2/28/11, there was no dressing observed behind the resident's left ear. On 3/1/11 at 8:55 a.m., the resident was observed in bed. He did not have a dressing in place behind his left ear. Interview with LPN # 1, at that time, indicated there was no dressing in place behind the resident's left ear. She indicated he was to have a Duoderm dressing in place. The area behind his left ear was observed to have a area 0.5 centimeters by 0.2 centimeters in size, and the area was red in color. LPN #1 indicated the resident was receiving Hospice services and the Hospice Nurse and the facility staff nurses provided the	F0314	Allegation of Credible Compliance This Plan of Correction is prepared and executed because it is required by the provision of State and Federal law and not because Autumn Hills Health and Rehabilitation Center agrees with the allegations and citations listed. Autumn Hills Health and Rehabilitation maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. This Plan of Correction shall also operate as the facility's written credible allegation of compliance, please accept March 31, 2011 as the date of compliance.**F314 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Resident #E: Area to left ear was assessed and wound was closed. MD was notified and treatment was changed to palliative Duoderm dressing every 3 days, and new dressing was applied. Orders were also obtained to check placement of wound dressings every shift and replace if soiled or dislodged. 2) How other residents having the potential to be affected by the same deficient practice will be**	03/31/2011

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	pressure ulcer treatments for the resident. The record for Resident #E was reviewed on 2/28/11 at 10:00 a.m. The resident had diagnoses that included, but were not limited to, congestive heart failure, cerebral vascular accident (stroke) with right hemiparesis, and chronic sacral decubitus ulcer. The resident had pressure ulcers behind his left ear, behind his right ear and on his coccyx. There was a physician's order, dated 2/22/11, that indicated, "Cleanse behind left ear with Saf Clenz, pat dry, apply Aquacel and cover with Duoderm, change q (every) 3 days." There was an entry in the Nurse's Notes, dated 2/22/11 at 2:00 p.m., that indicated, "N.O. (new order) received to apply Saf Clenz et (and) apply Aquacel et cover with Duoderm, change q 3 days." The form titled "Pressure Ulcer Report Report" was reviewed. There was an entry, dated 2/22/11, that indicated the resident had a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed with no slough) pressure ulcer behind his left ear. The area measured 0.3 centimeters in length by 0.5 centimeters in width with a		**identified and what corrective actions will be taken: All residents with dressing orders were checked for placement of dressings, and all were in place as ordered. 3) What Measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All residents with dressing orders will be checked every shift for placement of dressings and will be documented on the treatment record. The wound nurse will randomly check at least 2 residents per day 5x/wk to monitor compliance. The results of these audits will be forwarded to QA for review and any concerns will be addressed. Licensed staff have been in-serviced regarding wound care, dressing change protocol and monitoring of dressing placement every shift. Certified Nursing Assistants will be in-serviced regarding notifying nurse if dressing is not present or becomes soiled or dislodged during care, and that CNA's are not to remove dressings. 4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The QA committee will**	

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	depth of less than 0.1 centimeters. Review of the form titled "Skilled Nursing Comprehensive Assessment," dated 2/28/11, indicated the form was completed by the Hospice Nurse. The documentation indicated the Hospice Nurse had visited the resident from 12:50 p.m. until 2:40 p.m. She indicated that she had changed the pressure ulcer dressing to the resident's coccyx. She did not indicate that a dressing was applied to the resident's left ear. Interview with the Nurse Consultant on 3/1/11 at 11:30 a.m., indicated the facility nurses should replace pressure ulcer dressings when they have become soiled or dislodged. She indicated there should have been a dressing in place behind the resident's left ear as ordered by the physician. b. The forms titled "Skilled Nursing Comprehensive Assessment," completed by the Hospice Nurse were reviewed. The "Skilled Nursing Comprehensive Assessment," dated 2/28/11 indicated, "Dressing changed to coccyx. Stage III (full thickness tissue loss) with minimal drainage, No dressing on decubitus upon visit." The "Skilled Nursing Comprehensive Assessment," dated		**review the results of these audits monthly x3 and then quarterly x2. 5. Date of compliance 3/31/11**	

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	2/21/11, indicated "Dressing change to coccyx. Previous dressing not in place. Coccyx open to air. Dimensions of stage III decubitus 2 cm (centimeters) long 1.5 cm wide 1.2 cm deep. Surrounding edges of circular decubitus has undermining of 1 cm." The "Skilled Nursing Comprehensive Assessment," dated 2/14/11, indicated, "Dressing change to coccyx. No dressing was on coccyx at time of dressing change." The form titled "Pressure Ulcer Report Report" was reviewed. There was an entry, dated 2/4/11, that indicated the resident had a Stage IV (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer on his coccyx. The area measured 2 centimeters in length by 2 centimeters in width with a depth of less than 1 centimeter. There was an entry, dated 2/23/11, that indicated the coccyx pressure ulcer was a stage III and was 1.6 cm in length, 1 cm in width and .75 cm in depth. There was a physician's order, dated 2/4/11, that indicated, "Cleanse coccyx wound, pack loosely with Alginate, cover with Polymem foam and cover with Duoderm, change qod (every other day) and prn (as necessary."			

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	Interview with the Nurse Consultant on 3/1/11 at 11:30 a.m., indicated there should have been a dressing in place on the resident's coccyx pressure ulcer as ordered by the physician, when the Hospice Nurse made her visit. This Federal tag relates to Complaint IN00086395 3.1-40(a)(2)			

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F0514 SS=D	Based on record review and interview, the facility failed to ensure the assessment of a resident's wound was documented for 1 of 4 residents reviewed with pressure ulcers in a sample of 5. (Resident #B) Findings include: The record for Resident #B was reviewed on 2/28/11 at 2:30 p.m. The resident had diagnoses that included, but were not limited to, diabetes, hypertension and bilateral below knee amputation. Review of the record indicated the resident was transferred to the hospital 1/30/11 due to an altered mental status. The resident was readmitted to the facility on 2/10/11. Upon readmission to the facility the nurse completed an admission assessment. The form titled "Admission Nursing Assessment" and dated 2/10/11 was reviewed. The comments section of the skin assessment indicated the resident had a 6 cm (centimeter) x 4 cm reddened area on the right forearm, a 7 cm x 6 cm bruise on the right hand and a 0.5 cm x 0.9 cm x 0.3 cm coccyx pressure wound. There was no assessment of the resident's right stump area.	F0514	Allegation of Credible Compliance This Plan of Correction is prepared and executed because it is required by the provision of State and Federal law and not because Autumn Hills Health and Rehabilitation Center agrees with the allegations and citations listed. Autumn Hills Health and Rehabilitation maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. This Plan of Correction shall also operate as the facility's written credible allegation of compliance, please accept March 31, 2011 as the date of compliance. **F514** **1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** **Admission Nursing Assessment for Resident #B was updated as a late entry by LPN #3 to include assessment of right stump.** **2) How other residents having the**	03/31/2011

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	The physician's orders on the transfer form from the hospital indicated, "right stump dressing change daily with ABD (a large dry dressing) and Kerlix. Elevate the stump at all times." Review of the hospital wound care note, dated 2/8/11 at 1514 indicated, "Consult sent for wound care re: right stump. Upon assessment Pt (patient) has 6.0 cm x 5.0 cm DTI (deep tissue injury) noted. We will turn q 2 hours and off load bilat (bilateral) stumps. We will apply dry ABD and secure with Kerlix, change daily." The resident was sent to the hospital on 2/15/11, he has not returned. Interview with the Nurse consultant on 3/1/11 at 11:00 a.m., indicated the resident was discharged at 2:04 p.m. on 2/15/11. Review of the record indicated there was no assessment of the resident's right stump from his readmission on 2/10/11 through his discharge to the hospital on 2/15/11. Upon admission to the hospital, a skin assessment was completed. Review of the hospital wound note, dated 2/15/11 at 1630 (4:30 p.m.) indicated the resident's right stump had a black (non-viable) area measuring 12 cm by 18 centimeters.		**potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** **All Admission Nursing Assessments completed since 3/1/11 have been reviewed to ensure accuracy and completion of skin assessment documentation.** **3) What Measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** **The Wound Nurse or designee will audit all Admission Nursing Assessments to ensure accuracy and completion of skin assessment documentation. The results of these audits will be forwarded to QA for review and any concerns will be addressed.** **Licensed staff were inserviced regarding accuracy and completion of skin assessment documentation on the Admission Nursing Assessment.** **4) How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** **The QA committee will review the results of these audits monthly x3 and then quarterly x2.**	

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	Interview with LPN #3 on 3/1/11 at 9:00 a.m., indicated she was the nurse who completed the "Admission Nursing Assessment" that was dated 2/10/11. She indicated that she had assessed the resident's right stump but did not document the assessment. She indicated the area was black, purple and maroon in color. She indicated the area was not open. She indicated the area was 6 cm by 4 cm in size. Interview with the Nurse Consultant on 3/1/11 at 10:00 a.m., indicated there was no documentation of the resident's right stump upon readmission to the facility on 2/10/11. She indicated as assessment of the area should have been completed. This federal tag relates to Complaint IN00086395 3.1-50(a)(1)		**5. Date of compliance** **3/31/11**	